THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-9076.M5

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** ( ) Yes (X) No
Requestor's Name and Address Pain & Recovery Clinic of North Houston 6660 Airline Drive Houston, Texas 77076	MDR Tracking No.: M5-05-2210-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Company Box 54	Date of Injury: Employer's Name: Insurance Carrier's No.: 000055877

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	**To**		
04-07-04	**08-31-04**	**97035, 97140, 97110, 97112 and 99212**	☒ **Yes** ☐ **No**
09-16-04	**10-26-04**	**97140 and 97112**	☐ **Yes** ☒ **No**
			☐ **Yes** ☐ **No**

PART III: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

Per Rule 133.308(e)(1) dates of service 04-05-04 and 04-06-04 were not timely filed and therefore were not part of the review.

The Division has reviewed the enclosed IRO decision and determined that the requestor **prevailed** on the **majority** of disputed medical necessity issues.

PART IV: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to a refund of the paid IRO fee in the amount of $460.00. The Division hereby **ORDERS** the insurance carrier to remit this amount and the appropriate amount for the services totaling $5,720.05 in dispute consistent with the applicable fee guidelines, plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order.

Findings and Decision By:

	Debra L. Hewitt	06-30-05
	Typed Name	Date of Findings and Decision

Order By:

	Margaret Ojeda	06-30-05
Authorized Signature	Typed Name	Date of Order

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

PART VI: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

MEDICAL REVIEW OF TEXAS

[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-05-2210-01
Name of Patient:	___
Name of URA/Payer:	Pain & Recovery Clinic of N. Houston
Name of Provider: (ER, Hospital, or Other Facility)	Pain & Recovery Clinic of N. Houston
Name of Physician: (Treating or Requesting)	Dean R. McMillan, DC

June 21, 2005

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Texas Workers Compensation Commission

CLINICAL HISTORY

Available documentation received and included for review consists of records from Drs Martinez & Patel (DC) McMillan, Drs Varon, Xeller, Larolinic (MD) Dr. Lamarra (DPM). MRI & CT reports (Lee, MD) and treatment notes Meekins, (LPT), Turboff, LPC

Mr. ___, a 58-year-old male, injured his right thumb, left ankle and lower back while working as a truck loader for a moving/storage company. He was unloading scaffolding boards from one trailer to another when he fell approximately 5 feet, landing on his lower bank. Some boards fell through a gap, landing on his left lower extremity, as well as on his right hand, specifically his right thumb. He was initially assessed by Dr. Gable, (MD) who assessed comminuted fracture of the distal phalanx with dorsal displacement. It was manually reduced, then splinted. On 4/5/04 he presented to Houston Pain Clinic and was evaluated by Dr. McMillan (MD), complaining of persistent right hand pain, left foot/ankle pain and low back pain. Assessment was of lumbar radiculitis, internal derangement of the left ankle and fracture of the right thumb. Conservative intervention was initiated consisting of manual therapies to the lumbar and left ankle area, along with stim and ultrasound. On 4/12/04 some exercises were added, consisting of lower body stretching and strengthening, along with neuromuscular reeducation including Swiss ball band and wobble board, for a total of 14 sessions through 5/17/04. Orthopedic consult was obtained from Dr. Jarolimic on 5/3/04. Distant was of S/P crush injury right thumb, with comminuted and angulated fracture of the proximal phalanx and grade 2 left ankle sprain.

On 5/3/04, MRI was obtained of the lumbar spine and revealed multilevel disk bulges at L1-L5/S1 with a central disc herniation & stenosis at L4/5 and foraminal stenosis (mild) at L4/5 and L5/S1 bilaterally. MRI of the left ankle revealed soft tissue lymphedema and small ankle effusion, residual grade 1 medial and lateral ankle sprains and significant trabeculae injury of the anterior and inferior aspects of

the talus, predominantly in the medial aspect with a small nondisplaced 1 cm avulsed fragment involving the medial cortex portion of the talus.

On 5/14/04 the patient was evaluated and subsequently treated with physical therapy which included manual therapies, therapeutic exercises and neuro-muscular reeducation. This continued for 30 sessions through 7/27/04.

The patient was evaluated on 6/21/04 by a podiatrist, Dr. Lamarra. His assessment was of a fractured talus, crush injury, ankle sprain and Intel ankle derangement along with the sinus tarsi syndrome. His place and walking boot.

Patient was reevaluated on 7/7/04 by Dr. McMillan, who noted that the thumb was continuing to deteriorate. Minimal lower back findings were noted, with tenderness from L3-S1 centrally, full but painful range of motion. Patient is referred back to Dr. Jarolimic to evaluate the thumb. This was performed on 7/26/04. Dr. Jarolimic who recommended hand therapy.

Patient continued with physical therapy for further 35 sessions through 10/26/04.

On 8/2/04, the patient was evaluated by a hand specialist, Dr. Varon, who recommended contracture releases of the IP and MP joints with Tenolysis. Electro diagnostics were performed on 8/3/04 revealing a mild degree of compromise the L5 nerve root.

The patient underwent a contracture release of the MP and IP joints of the right thumb with capsulotomy, flexor pollicis brevis Tenolysis, digital nerve neurolysis and pollicis tendon repair on 12/5/04.

REQUESTED SERVICE(S)

The notification of IRO assignment presents that the items in dispute include the medical necessity of ultrasound (97035), manual therapy (97140), therapeutic exercises, (97110), neuromuscular reeducation (97112), office visit (99212). 04/07/04-10/26/04.

DECISION

Approve all services through 8/31/04.

Deny all services beyond 8/31/04.

RATIONALE/BASIS FOR DECISION

The standard of medical necessity in Workers Comp, according to the Texas labor code 408.021 (entitlement to medical benefits) is that an employee who sustained a compensable injury is entitled to all

healthcare reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to healthcare that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.

This is an elderly gentleman who sustained injuries to multiple areas of the body, and eventually requiring surgery to fix his thumb. Most of the disputed services appear to address the time frame of treatment. Treatment times on average appear to be between 90-105 minutes, addressing three separate body areas. The documentation establishes the appropriateness for a longer than the 'expected 45 minute treatment time requirement' considering the number of areas involved.

By most accounts, even considering the number of areas that were involved, his main problem beyond the end of August 2004 appears to be directed towards his thumb. It appears by this time that further, ongoing conservative intervention directed towards this area was of very little use and he was headed for surgery. There is no medical necessity established for treatment to either his lower back or ankle beyond 8/31/04. Ongoing, unrelenting care was not documented as necessary beyond this point.

The above analysis is based solely upon the medical records/tests submitted. It is assumed that the material provided is correct and complete in nature. If more information becomes available at a later date, an additional report may be requested. Such and may or may not change the opinions rendered in this evaluation.

Opinions are based upon a reasonable degree of medical/chiropractic probability and are totally independent of the requesting client.

References:

Hansen DT: Topics in Clinical Chiropractic, 1994, volume one, No. 4, December 1994, pp. 1-8 with the article "Back to Basics: Determining how much care to give and reporting patient progress".

Haldeman S., Chapman-Smith D, Peterson DM., eds. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen: Giathersburg, MD, 1993;

Souza T: Differential Diagnosis for a Chiropractor: Protocols and Algorithms, 1997; chapter 1, pp. 3-25.

Liebenson C. Commentary: Rehabilitation and chiropractic practice. JMPT 1996; 19(2):134140